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VOL. II.—11TH YEAR.

SYDNEY: SATURDAY, DECEMBER 27, 1924.

No. 26.

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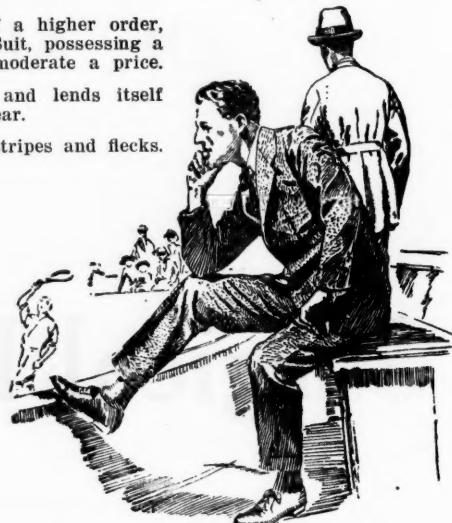
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An Address.¹

THE CINDERELLA OF MEDICINE.

By D. GIFFORD CROLL, M.B. (Sydney),
*Retiring President of the Queensland Branch
of the British Medical Association.*

My first duty is to thank you for the honour of having elected me to this post and for the patience and forbearance that you have shown throughout the year. I know that I am a poor speaker and an indifferent chairman, but not once have I been reminded of the fact, indeed there has seemed almost a conspiracy to inspire me with confidence. Your generosity in this matter I have greatly appreciated and I feel sure that it will reassure future aspirants for the position who may have some diffidence in that respect.

The past year has not been uneventful. First of all there was the session of the Royal Commission on National Insurance held in Brisbane. In giving evidence before this Commission we stated clearly that we were opposed to any scheme closely resembling the British plan of national insurance.

Later, a scheme, drawn up by Dr. J. V. Duhig, was accepted as a basis for the policy of the Branch and published in the journal.

The matter has since been under consideration by the Federal Committee who dealt with it on similar lines. The report of the Commission has not yet been published, but I believe that no very drastic steps will be taken and the whole business will serve as a useful preliminary exercise both for ourselves and the Government in arriving at a proper conclusion in this very important matter.

Although they did not reach Brisbane, I cannot pass on without reference to the visit of a party of American surgeons to the southern States. They made it part of their mission to advocate and explain the system of standardization of hospitals adopted by the American College of Surgeons. This is a matter of great importance and is the most practical method yet suggested of protecting the public against the indiscriminate operating of incompetent surgeons, which has been such a growing menace during recent years. The public cannot be expected to estimate correctly the ability of a surgeon, but it could at least seek the protection of a standardized hospital or of a surgeon who belonged to the staff of such an institution.

I should advise all those who are interested in hospital administration, to read the articles upon

¹ Delivered at the Annual Meeting of the Queensland Branch of the British Medical Association on December 12, 1924.

this subject in THE MEDICAL JOURNAL OF AUSTRALIA of May 10, 1924.

Whilst on the subject of hospitals I should like to refer to the establishment of The Brisbane and South Coast Hospitals Board, which has brought the administration of nearly all the public hospitals within its area under one head. This is a movement which should greatly add to the efficiency of our public hospitals and to the value of the training received therein by nurses and resident medical officers. The movement has been closely watched by your Council and the conditions which govern the admission of patients, appear satisfactory to us.

I now come to the most important event of the year, what may be described as the assumption by our Branch of adult responsibilities; the right to hold property, to sue and to be sued and to pay income tax; in short, the Branch is being incorporated as a company. Application has been made to the courts for incorporation, but certain minor alterations must be made in our constitution if we wish to avoid having the word "Limited" as part of our title. These alterations necessitate reference to London before they can be made.

Having thus briefly reviewed the events of the year, most of which you will find in the Annual Report, it is my privilege to address you upon a subject of my own choosing and my choice is midwifery which I have taken the liberty of calling the "Cinderella of Medicine." I have named it thus because I consider that it is the most neglected of all the branches of medicine and yet it is the one that should be the most highly esteemed. It is my intention to demonstrate the poor progress made in midwifery in the last fifty years, to examine the causes and, if possible, to suggest a remedy.

Fifty years ago takes us back to 1875. Consider for a moment the tremendous advances made in medicine, surgery, pathology, public health and all the specialities since that date. They are too well known to need any enumeration, if enumeration were possible. Then turn to midwifery and what advances do we see? Practically none, except the indirect aid it receives from modern medicine and surgery. Of what use today would be a text-book of medicine or surgery published in 1877, but I have just been reading a text-book of midwifery, issued in that year, which differs in no important respect from the latest publications of today. Here are extracts on two important subjects: the prevention of puerperal sepsis and application of forceps (Spiegelberg, 1877).

Everything must be done to facilitate the progress of delivery as far as practicable; only such manipulations must be performed in the parturient passages as are absolutely necessary and midwifery must be practised with scrupulously clean hands and arms, clean instruments, clean linen, clean articles of toilette and in pure air. To recapitulate, the following conditions must be present, if forceps extraction is to be fairly easy and safe. There must be no obstruction on the part of the cervix and vagina, the fetal membranes must be retracted and the head must be of normal conformation, must be favourably placed as regards the parturient canal and must have reached the lower half of the pelvic cavity. Under such circumstances the operation will be indicated, when it is absolutely necessary that a labour

be terminated on account of some danger that is threatening the mother or the foetus and when such termination cannot be brought about by any gentler means. This very general indication embraces all special conditions, which therefore I need not enumerate here. The above moreover is the only strictly scientific indication.

In actual practice, however, we meet with another indication arising out of undue protraction of labour, the consequent exhaustion of the mother and the danger which may be produced thereby. This latter indication is very indefinite and offers plenty of room for exercise of individual judgement. At the same time it is the one which gives rise to the majority of forceps extractions, of which by no means a few are solely performed in order to shorten the period of suffering or even to save the accoucheur time. Now it is undoubtedly true, as I have already had occasion to point out, that private practice makes demands and involves many considerations of its own, quite apart from purely clinical ones; so that we must not blame a man off-hand if he has applied the forceps merely with a view of sparing a woman some of the pangs of labour. But we have a right to insist that such operation of convenience shall be uninjurious and that he who undertakes them, shall both morally and mechanically have learned to control his hands and his instrument. Such, alas! is not always the case and hence what is intended to be a benefit to the patient is not infrequently in reality the opposite.

Pelvic contraction is almost universally regarded as an additional indication and I have already, in the "Pathology of Labour," laid down the conditions under which the forceps may be used. Here, therefore, I shall merely again call attention to the fact that the forceps can only force the "strait," by exposing the life of the child to great risk and by seriously damaging the maternal parts. The instrument cannot remove the pelvic obstruction and can only very slightly reduce the bulk of the head, while, owing to its doing this in a single direction (transverse), it generally gives the head an unfavourable configuration. Hence it follows that the forceps can only be used with benefit where the head has already overcome the contraction, either through having traversed and got beyond or through having become moulded and adapted to it. Now under such circumstances delivery, of course, takes place spontaneously, provided there are good "pains." But if these are absent or too sluggish, consistently with the well-being of the mother or the foetus traction with the forceps may be a substitute. Unfortunately, however, it is not every medical practitioner who has sufficient knowledge for estimating the mechanical relations of labour and even the practised accoucheur may fall into error. Where therefore the accoucheur applies the forceps in a case of or on account of space disproportion, he should only use the instrument tentatively and never with the intention of terminating labour with its help, cost what it may.

Let us now turn to statistics and see what we find. In the first report of the Registrar-General of England and Wales, 1838, we find that per thousand births and miscarriages there were four maternal deaths. In the second report, 1839, there were per thousand births and miscarriages five maternal deaths.

From the report of the Registrar-General of Queensland we learn that there were:

In 1871—4.2 maternal deaths per 1,000 births.
In 1872—5.1 maternal deaths per 1,000 births.

In 1873—2.2 maternal deaths per 1,000 births.

Average for the three years: 3.83.

In 1921—5.0 maternal deaths per 1,000 births.

In 1922—4.6 maternal deaths per 1,000 births.

In 1923—4.8 maternal deaths per 1,000 births.

Average for the three years: 4.8.

This is apparently a worse state of affairs than fifty years ago and no better than England and Wales eighty years ago.

Let us examine some hospital statistics and see what light they throw on the subject. Thanks to the kindness of Dr. Marshall Allan, I have been able to obtain statistics of the Rotunda Hospital, Dublin, covering a period of nearly a hundred years.

The Rotunda Hospital had probably a lower death rate than any other large hospital in the last century, as the following figures suggest:

Between 1828 and 1849—

Maternité of Paris ..	41.8 maternal deaths.
Vienna Hospital ..	53.5 maternal deaths.
Rotunda Hospital ..	13.4 maternal deaths.

Death Rates per Thousand Births in Hospitals.

Between 1825 and 1875—

Rotunda Hospital ..	18.7 maternal deaths.
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Between 1868 and 1875—

Rotunda Hospital ..	20.8 maternal deaths.
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Between 1903 and 1910—

Rotunda Hospital ..	3.3 maternal deaths.
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The figures for the last period between 1903 and 1910 are the latest I have been able to obtain, but I have reason to believe that later figures show even better results.

As hospital figures have improved so much and are included in the total figures of the Registrar-General, it looks as if the records of private practice are even worse than they at first appeared.

All of the above refer to mortality alone. Unfortunately we have no morbidity figures of fifty years ago, but they probably conform approximately to the mortality figures.

I have, however, obtained some interesting information from our latest hospital reports. The annual report of the Brisbane Hospital for 1923 shows that two hundred and seventy-two women were admitted for conditions due to accidents and infections of pregnancy and labour, while one hundred and sixty-one women were admitted for typhoid fever, tuberculosis, syphilis and cancer. The morbidity of child-birth appears to be taking a higher toll than these four diseases combined.

From the annual report of the Lady Lamington Hospital, 1923, we learn that one hundred and twenty-five women were admitted for conditions due to the accidents and infections of pregnancy and labour, and two hundred and eighty-eight were admitted for all other conditions. The majority of these accidents and infections could probably have been prevented or possibly remedied at the time at which they occurred.

What are the causes of this regrettable state of affairs?

First of all there is the education of the medical student in obstetrics. That it is in most cases grossly inadequate few will deny, but great improvements are taking place. Herein, however, the solution does not lie. An excellent leader in THE MEDICAL JOURNAL OF AUSTRALIA of June 21, 1924,

sets out a proposed scheme for teaching midwifery. That it is an excellent scheme and quite as good, if not better than any other I have seen, I am quite willing to admit, but with the concluding remarks I entirely disagree: "It is scarcely necessary to state that if students were trained in this or a similar manner, they would go out into the world after graduation as competent obstetricians." I maintain that you cannot turn out competent obstetricians from any school except the school of experience. As well try to turn out from a training ship men who have never been to sea as competent master mariners. If we admit that we cannot turn out competent obstetricians from any school, I think that we arrive at the second cause and the crux of the whole question, that is how to continue the training after they leave the school. Midwifery in this respect presents peculiar difficulties which are not in common with other branches of medicine. First and foremost the work is isolated; a man aspiring to be a competent surgeon works at first with and under the supervision of experienced surgeons and, even when he starts to work for himself, his work is watched and his results criticised; this applies perhaps in a lesser degree to other branches of medicine. In midwifery, however, it is different. From the very beginning he works alone; his results are seldom seen by anyone else and even the patients are generally quite unaware to whether good or bad work has been done.

Under these conditions many men will conscientiously seek to improve their work and generally succeed in doing so. Unfortunately, however, there are some who have no further ambition than to get the case over quickly, to obtain the fee and to leave the people reasonably satisfied that the case has been properly conducted. Such a man, you will agree, must rapidly degenerate into a menace rather a help to women in child-birth and undoubtedly it is such men who are largely responsible for our unsatisfactory statistics.

Let us examine for a moment the usual methods of this type of man. When engaged for a case he ascertains the date from a table and may ask for a specimen of urine to be sent periodically, although even this precaution is frequently omitted. Unless the patient comes for some special reason, he does not see her again before the *accouchement*; nor does he bother himself much about the nurse; he leaves that to the patient. Patients usually desire to choose their own nurses, I know, but nevertheless the principle is wrong and tends to deteriorate the standard of nursing. In a normal case there is no greater service that a doctor can render his patient than the careful selection of a nurse. And if the nurses are thus selected, they will be more careful in carrying out their duties to the satisfaction of the medical attendant. Under the first system if a doctor is dissatisfied with the work of the nurse, he is in most cases almost powerless to rectify matters.

When labour has commenced and the nurse rings him up, the first and almost the only thing he asks is the amount of dilatation—this in order that he may know when he can get forceps on and end the labour. If he judges that the amount of dilatation

is sufficient for his purpose, he proceeds to his patient. From his bag he takes a bottle of chloroform and a pair of forceps; the latter he hands to the nurse to be sterilized by boiling, or possibly by just pouring hot water over them. While she is doing this, he gives the patient some chloroform and then washing his hands in a perfunctory manner, proceeds to apply the forceps, dilating the cervix to get them in, if necessary. He then extracts the child, stitches the tears in the perineum—he is often an expert at this—expresses the placenta by pressing heavily upon the fundus and departs. He will probably visit the patient two or three times afterwards, once at least to remove the stitches, but he does not generally trouble to make a vaginal examination to examine how much damage he has done to the cervix.

The worst of it is that many patients—I might almost say the majority—prefer this method of treatment, not realizing the harm that is being done to them. They like to choose their own nurse; they do not like being bothered with examinations beforehand; they like the doctor who gives chloroform, applies the forceps and gets it over quickly. They do not mind the stitches, in fact they rather like to be able to say they had a lot of stitches. They do not for a moment realize the years of ill-health and probable operations which will follow in consequence. In a leading article in THE MEDICAL JOURNAL OF AUSTRALIA of September 20, 1924, the following statement appeared:

The general practitioner will admit that the relatives and friends, aided and abetted only too often by the nurse or midwife, often clamour for the early application of forceps and rapid delivery. If the general practitioner refuses and continues to refuse to be party to this form of meddlesome midwifery, his services will not be required on future occasions or for other patients and a less scrupulous practitioner will be called in. It is obvious that a public campaign must be started to educate the public concerning the disadvantages and dangers associated with the unnecessary application of forceps and indeed with all unneeded forms of interference with Nature.

The third cause is that the great majority of capable and conscientious *accoucheurs* give up midwifery just as they are becoming highly efficient therein.

There are two reasons for this: (i.) The tax of the necessity of being available at all times and of not being able to make any definite appointment or engagement. When a man is attending over a hundred confinements in a year, he is never free. The best way that I can see to obviate this would be by team work, but it would be difficult to get the patients to accept it. (ii.) The second reason is that if done properly, it is very poorly paid. The recognized fee for a confinement is five guineas. Many, of course, can command more and there is not the least objection to their doing so. The fact remains, however, that five guineas is the recognized fee. Now let us see what the doctor is supposed to do for this five guineas.

Professor B. P. Watson, of Edinburgh, lays down the following requirements during pregnancy: (i.) A thorough general examination early in pregnancy and a special examination of physical configuration;

(ii.) a careful watch at regular intervals throughout pregnancy and appropriate treatment whenever the least departure from the normal is detected. Presumably he included periodical examination of urine in this.

Dr. E. H. Tweedy, Master of the Rotunda Hospital, lays down the following requirements for the conduct of labour: (i.) An examination when labour commences to ascertain the position of the fetus, the rate of the foetal heart *et cetera*; (ii.) the obstetrician may not leave after the membranes have ruptured or the second stage has commenced; (iii.) he must wait for the placenta one hour, if necessary, before attempting removal; (iv.) he must remain for one hour after the delivery of the placenta; (v.) he must pay a daily visit for six days; (vi.) he must pay four more visits on each alternate day and carry out an examination in six weeks' time.

Conduct of labour under these conditions would take on an average at least two hours. The number of additional visits would be at least sixteen. In addition to this there is the tax of being always on call. It is not surprising that men give it up for other branches.

Someone may well ask: "But why not raise the fee?" The question is reasonable and there is much to be said in favour of the suggestion, but there is also an objection. In no branch of medicine is it so undesirable to increase the fee, for we are dealing mostly with young married people who are struggling to make a home and rear a family on a rather inadequate income. In later years many of them will be able to pay big fees, but not at present. They get a five pound bonus, it is true, but the average confinement with medical fees and nursing or hospital costs fifteen pounds. This is not out of the way, but with the least complication it can soar very quickly and if there is any serious difficulty it can easily reach fifty pounds or one hundred pounds. This is a matter for which a remedy is urgently required. The present maternity public hospitals do not serve the purpose. Women, except those of the poorest classes, are reluctant to enter them. What are the reasons for this? I think that in the first place it is because the service, so far at least as the honorary medical staff is concerned, is free. Most people have a certain amount of independence and do not like free or charitable treatment. Secondly there is only one large maternity hospital in Brisbane and a woman feels that in going there she is losing her individuality; she becomes just a patient. If there were a number of smaller hospitals in the different suburbs and preferably not entirely free except to the absolutely necessitous, they would be much more generally used.

Thirdly there is the question of nursing, but this I do not admit as a primary cause. The responsibility in this matter lies on the medical profession and the Government. Bad nursing would soon be abolished if the medical work was good and good nursing is of little avail if the medical work is bad.

With the idea of leaving the management of labour entirely to the nurse and letting the doctor do only the pre-natal and post-natal work, I have

little sympathy. It would in the first place be a retrograde step and we should be further than ever from improving the status of midwifery, although the nurses would probably not do so much harm as some doctors do at present. Also there is the question of anaesthetics. Most women insist and rightly too that some anaesthetic shall be used to relieve the pain. To allow the general use of anaesthetics by nurses would, in my opinion, be entirely wrong and would be followed by a series of disasters, which would quickly put a stop to the practice.

I must also refer briefly to the question of home *versus* hospital for the conduct of labour. I do not deny that labour can be properly conducted in a home provided that it is allowed generally to take its natural course. But there is no doubt that it is far easier to carry out a well conducted labour in a hospital and if any complication arises, the advantages of a hospital are immediately obvious.

As I have previously shown, the advance already made, appears to be in hospitals. Then there is the question of expense. If we are to reduce the cost, it can undoubtedly be done far more effectively in hospitals than in private homes. In fact with two or three men serving a hospital the cost could be reduced very much indeed, especially if the patients did not specify which doctor was to attend them.

Now let us consider what can be done to improve matters. There are two objectives: (i.) To establish some sort of supervision or check upon the work of incompetent or unscrupulous practitioners; (ii.) to retain in the practice of midwifery as many as possible of the men who show special ability. For the accomplishment of this there is a very powerful weapon in the Commonwealth Maternity Allowance (Baby Bonus). It is generally agreed that it is not at present serving its purpose, but with the addition of a very little extra expenditure I propose to show how it could be made to do so very effectively.

It was intended to enable women to obtain proper medical and nursing attention during their confinements, but no provision is made to see that they obtain it and very often they do not, either from their own fault or that of their attendants.

If before paying the bonus the Government were to insist that the following reports were made, a great improvement in the standard of midwifery would immediately follow: (i.) A detailed examination of the mother six weeks before giving the physical configuration, position of the fetus and so forth and the probability or otherwise of normal labour; (ii.) a brief history of the labour with particulars of any resultant injuries and steps taken to remedy the same; (iii.) examination one month after labour.

Penalties would have to be provided for filling in these reports incorrectly or without examination. Doctors quite reasonably would expect to be paid for making the reports and clinics would have to be established in every important centre where women could have the examination made and the first and third reports filled up free of charge. They could,

if they preferred, have them made by their own doctor at their own expense. But if the examinations were made at a clinic and a private doctor engaged to attend the confinement, a copy of the report should be made available to him.

The following results should ensue:

1. The public would soon be educated up to the necessity of such examinations and although a number would undoubtedly refuse the bonus under these conditions, they would nevertheless expect their doctor to carry out the prescribed examinations.

2. A record and a watch would be kept upon the work of all men doing midwifery and would undoubtedly act as a very effective restraint upon careless and meddlesome work.

3. The clinics, examination of the records and administration of the scheme would provide employment for a number of competent obstetricians who would otherwise retire and the expense would be largely defrayed by the number of well-to-do people who would refuse the bonus. The pre-natal and post-natal examinations should be made, not by young graduates, but by men of experience and proven ability.

4. Some men, when they gave up the practice of active midwifery, would undertake this work in a private capacity. Many of their old patients would come to them. After making the pre-natal examination they would often be asked to recommend a man to undertake the labour and the younger men in their turn would probably call the older in consultation in the event of serious difficulty arising in the confinement and injury occurring which would be disclosed at the post-natal examination or especially if the labour did not follow the course predicted in the ante-natal report.

All this, I think, would tend to improve greatly the status of midwifery and to reduce the rate of mortality and morbidity. Perhaps eventually it would lead to the "Cinderella of Medicine" taking her rightful place amongst the sister branches.

SOME NOTES ON THYREOID THERAPY.

By FRED. J. T. SAWKINS, M.B., Ch.M. (Sydney),
Relieving Medical Officer, Mental Hospital,
Kenmore, New South Wales.

It has always seemed anomalous to me that the administration of small doses of thyreoid gland substance in the various manifestations of hypothyroidism should be spoken of as "thyreoid feeding," while heroic dosing with five grammes or more daily obtains the milder term of "thyreoid treatment. That, however, is by the way.

With regard to this treatment by large doses, I have not yet read or heard any attempt to explain the rationale of its use, nor of the often remarkable results obtained thereby in certain cases of mental diseases. The immediate effects are, of course, more than could be accounted for by the making good of any mere deficiency of thyreoid

secretion by the patient. In fact and in practice the question of his or her thyroid adequacy or inadequacy is an unconsidered trifle and not a determining factor in its exhibition. Starting with, say, three 0.3 grammé tablets daily and working up to five grammes, the usual but quite arbitrary limit is reached; the dosage may be then immediately stopped or gradually reduced, the time of treatment varying from three weeks or a month to six weeks according to varying factors.

During treatment the patient is kept in bed on a diet modified to suit the individual reaction thereto. A preliminary three days' rest in bed with a daily enema is usual and the condition of the digestive and eliminative tracts must be carefully attended to, the patient's weight weekly noted and the effect on the heart's action faithfully observed and recorded.

In most cases there is a gradual loss of weight, the pulse rate is increased with decreased tension. There is increased perspiration and frequently a fine tremor is demonstrable when with extended arms the patient is induced to spread out his hand with fingers parted. A degree of anaemia is usual and in the later days of the treatment a distaste for food or actual vomiting may supervene. This last, associated with much loss of weight, definite anaemia, profuse sweating and a weakening pulse, whose range persists at about 120, is quite sufficient to induce the medical attendant either to reduce the dose or to omit the thyroid medication altogether. Unless there be some inter-current disease the temperature throughout remains normal or subnormal.

Briefly stated then the effect of the treatment is to produce a greatly increased metabolism, resulting in a condition clinically similar to that caused by an acute specific fever minus, of course, the pyrexia and the other injurious organic effects of a specific toxin.

Afterwards and this is the fact to be borne in mind, there follows the delightful condition of convalescence, during which the patient is easily suggestible. This is the time for the practical psychologist to get in his good work and to initiate or to help to initiate a new and healthier mental attitude to whatever has hitherto been inimical in the patient's environment. One can then find out and possibly correct or explain what he has been repressing and allowing to express itself viciously and suggest other and healthier and saner outlets for the repressed complex.

The above is at any rate a sufficiently feasible and working explanation of the phenomena observed during and after thyroid treatment.

A few words as to suitable subjects. Evidently debilitated patients from any cause whatever may not be given thyroid. Those with quiescent tuberculous trouble would run the risk of a recurrence; the same applies to patients with (to coin a word) sub-active syphilitic disease.

Hitherto I believe the treatment has been reserved almost entirely for comparatively recent cases of *dementia praecox* in comparatively young patients. My few years' experience has impressed me with the frequency of the good results accruing in these cases

as well as their occasional brilliancy. On the other hand I have been no less impressed with the apparent absence of reaction in some from whom, in one's ignorance or inexperience, one expected good results.

Again, as I became accustomed to give these heroic doses and to extend their use, it has been strongly borne in on me that quite other mental conditions may be improved in selected cases by taking advantage of this artificially induced stage of convalescent suggestibility. Even when there has evidently been a definite degree of established dementia associated with long periods of inferior conduct and even in elderly patients, I have had the great pleasure of seeing judiciously planned and carefully carried out thyroid treatment followed by extraordinarily gratifying results, manifested by improved conduct and behaviour, much more striking and arresting than the recovered use of a limb or even the function of a special sense.

For example, let me cite the case of a man of over fifty, who for twenty years had been an inmate of one or other of the mental hospitals and for the greater part of that time in a so-called refractory ward, needing continual observation. An idle, mean, pestilential fellow, an adept at the petty sneak-thieving, possible even in the well-officed wards of an up-to-date mental hospital, and especially delighting in the necessarily few and therefore to such a man more highly prized chances of fomenting trouble among his fellow recalcitrants, a patient who could never be trusted in his speech or conduct. For some glaring acts of misconduct it became necessary to put this man in seclusion if only *pour décourager les autres*.

As a sort of forlorn hope, but on the suggestion of the much experienced and reliable charge attendant, I put him on thyroid treatment. In passing I cannot but record my gratitude for the valuable suggestions and the education I have received from the various attendants. Who so capable of judging of the mental peculiarities and conduct of patients than those who are in hourly contact with them day after day? This man ascended the scale of thyroid treatment till he was taking five grammes daily. The dosage was then gradually diminished to 0.3 grammé *per diem*. During the latter part of the treatment he increased in weight and vitality generally and particularly in sociability. He could and did talk interestingly of his past experiences and evinced a definitely sane ambition for his future. This was no mere flash in the pan, for as soon as he was physically strong enough, he began to employ his time for the good of the ward. Later he was at his own desire allowed to work out in the grounds under the supervision of an outdoor attendant. After a few months' trial he was made the trusted messenger of the gang. He could be trusted to go about the grounds—an extensive area without escape-preventing walls or fences. All this time he improved in physique and above all he regained his self-respect. He was eventually discharged and has now for a few years been maintaining himself and as far as we know behaving himself as a good citizen.

This is, of course, in my short experience, an extreme case. But I am reminded of others, less spectacular ones, cases of early dementia which, in large wards where individual attention must necessarily be limited, would gradually and naturally decline into deeper dementia. I have seen such conditions arrested on their downward path and though no treatment can replace a nerve cell once destroyed nor cure an established condition of dementia, one must applaud and persist in any course of treatment, which not only tends to prevent a further declination, but enables some partially demented person to use to his own and his neighbours's advantage what remains of his original brain equipment. The more I see of judiciously used "thyroide treatment," the more am I convinced of its use and of its applicability to types of mental disease not hitherto considered suitable.

I have to thank the Inspector-General of Mental Hospitals, Dr. Eric Sinclair, for his permission to publish the above notes based on cases treated at Kenmore Mental Hospital.

Reports of Cases.

DUODENAL ULCER.

By J. H. HALLIDAY, M.B., Ch.M. (Sydney),
Resident Medical Officer, The Coast Hospital,
Sydney.

A MALE patient, aged forty-three years, was admitted to hospital on September 4, 1924. The history given by the patient was that he had had a feeling of fullness in the epigastrium with pain coming on two and a half hours after meals for a period of two years. The pain had been situated mainly under the right costal margin and radiated across the epigastrium to the left. These symptoms were relieved temporarily by the ingestion of food. For the nine months prior to admission the patient suffered from attacks of haematemesis. The blood was sometimes bright red and sometimes dark. The day before admission he collapsed while at work and vomited a large quantity of dark brown fluid. He subsequently complained of epigastric pain and giddiness. He gives a history of alcoholism for many years, having drunk brandy and beer for twenty years. He had appendicectomy performed six years ago.

On examination on admission the patient appeared very blanched, the conjunctive and mucous membranes were apparently bloodless. The pulse was feeble and rapid. The abdomen was soft and definitely tender in the epigastrium. A hypodermic injection of 0.01 grammes of morphine was given. This was repeated in four hours.

On September 5, 1924, no vomiting had occurred since admission and the condition of the pulse had improved. The heart did not appear to be dilated. A systolic murmur at the mitral region was conducted towards the axilla. The hypodermic injection of morphine was repeated. The patient was given Sippy's diet.

On September 7, 1924, the condition of the patient was improving, but there was evidence of melena in the stools.

On September 9, at 9 p.m. the patient complained of severe abdominal pain which was relieved by the hypodermic injection of 0.01 grammes of morphine. Later on the patient had three attacks of haematemesis and vomited five hundred and sixty-eight cubic centimetres (one pint) one hundred and eighty cubic centimetres (six ounces) and one hundred and twenty cubic centimetres (four ounces) of dark blood. Hypodermic injections of 0.01 grammes of morphine were given every four hours. The patient was very blanched and the pulse was rapid and thready. In the afternoon his condition became worse and he complained of pain in the epigastrium. One cubic centimetre

of adrenalin hydrochloride was ordered to be taken in iced water (eight cubic centimetres) every two hours. Rectal injections of glucose, bicarbonate of soda and brandy were ordered to be given every six hours. The same evening transfusion of blood was carried out, five hundred and sixty-eight cubic centimetres being injected. During the operation the patient vomited some clear fluid.

On September 10, 1924, the patient's condition had improved, but he was kept under the influence of morphine.

On September 11, 1924, the patient vomited one hundred and eighty cubic centimetres of blood, melena also occurred.

On September 13, 1924, the patient was given Sippy's diet and later complained of epigastric pain. Morphine (0.01 grammes) was given by hypodermic injection. The patient's pupils remained contracted.

On September 14, 1924, the patient was seen by a surgeon who did not advise operation.

On September 16, 1924, the patient vomited two hundred and forty cubic centimetres of blood. His condition was very low and he died on the following morning.

At *post mortem* examination all the organs were found to be very blanched. No macroscopical changes of cirrhosis of the liver could be seen. A chronic ulcer of the first part of the duodenum was found, it was the size of a shilling and in its floor was seen the gaping perforation of a large vessel. Two smaller perforations were found in a second vessel. Nothing else of an abnormal nature was found with the exception of a large retention cyst of the left kidney. Dr. Mona Ross examined a section of the uterus and reported that many coils of small intestines were filled with blood and that the changes were inflammatory.

Reviews.

THE PNEUMOCOCCUS.

An excellent review of the modern knowledge concerning the pneumococcus and pneumococcal affections is now available in English, since D. S. Page and Eva Morton have translated the monograph of Cotoni, Truche and Mademoiselle Raphael on this subject.¹ These authors set out primarily to describe the work done in Nicolle's laboratory, but they refer to the most important recent researches by other workers and provide a valuable bibliography. The book falls naturally into three sections which are concerned with the organism, the diseases caused by it and with serum, vaccine and chemo-therapy.

The most interesting observations recorded concern changes in virulence of pneumococci. The authors have demonstrated fluctuations, sometimes indeed increase of virulence *in vitro* under the special conditions of culture which they adopt. A striking feature of their results is the absence of evidence of increased virulence in their extensive passage experiments except in a few isolated instances. They also show that generally speaking virulence and antigenic power go hand in hand. For active immunity produced by vaccination virulent strains should therefore be used, even when the vaccination is with living organisms.

Variation in the intensity of immunizing power is associated with variability in the valency of organisms. Those of high valency appear to produce immunity more readily against some strains than against others. In passive immunity the animal in which the immune serum is prepared, that in which the serum is tested, and the virulence of the strain used for immunization, are all of importance. Some animals produce antibodies against the pneumococcus more readily than others "and the passively immunized animal is not strictly passive, but may take an active part in revealing the properties of the inoculated serum."

The trend of modern investigation is decisively against any further tenure of the view that lobar pneumonia is a

¹ "The Pneumococcus and Pneumococcal Affections," by L. Cotoni, C. Truche and Mlle. A. Raphael; English Edition by D. S. Page, M.A., M.B. (Cantab), D.P.H., and Eva Morton, M.R.C.S. (England), L.R.C.P. (London); 1924. London: John Bale, Sons and Danielsson, Limited, Royal 8vo, pp. 218, with numerous figures and charts. Price: 16s. net.

septicæmia with an accompanying local lung lesion. True pneumococcal septicæmia is a rarer and more serious condition.

The book contains an excellent clinical study of pneumonia, with a very clear statement of the modern conception of the nature of the crisis as the substitution of a secondary intoxication for an acute infection. It presents a symptom-complex which closely resembles anaphylactic shock and is due to the rapid destruction of accumulated pneumococcal antigen by lytic antibody.

A good summary of the effect of serum treatment is given in conclusion in the words of Sacquéepe: "On the whole the results obtained are satisfactory. Somewhat variable perhaps according to the potency of the serum, somewhat limited in its action by contingencies which are probably accidental, sero-therapy nevertheless constitutes for the moment a very useful measure which in most cases is efficacious. It is worth adopting and when the clinical condition indicates its employment, we know at present of no other treatment which gives such good results in pneumonia in adults."

EPILEPSY.

In "Clinical Studies in Epilepsy" Dr. Donald Fraser takes as his text the case of a Mr. X., whose epilepsy commenced in early adult life and continued for over forty years.¹ Mr. X. was a minister of religion and records his symptoms before and after an attack with more than ordinary intelligence.

Epilepsy is rather a vague term and Dr. Fraser has made it to include the epileptiform convulsions of general paralysis, cerebral syphilis and those occurring with gross brain lesions as tumours, in our opinion too wide an acceptance of the meaning of the word.

The possibility of a psychogenic origin of epilepsy is discussed and the author refuses to accept this as a possibility, in which we are in sympathy with him, as we understand the word epilepsy.

But it is not clear that the case of Mr. X. is one of pure epilepsy, as opposed to hystero-epilepsy or epilepsy of psychogenic origin. Mr. X. is much troubled with aphasic attacks. The attacks occurred usually on Sundays and often commenced an hour or two before the service he was about to take. They abated some time after he had given up the ministry.

Dr. Fraser quotes the histories of several patients who have been cured by cautery to the scalp or elsewhere and one who was cured by a severe application of "butter of antimony" to her big toe. The author has not used this treatment, but apparently regrets neglecting his opportunities.

We would look upon these cases as being of psychogenic origin, the cautery being the means of applying suggestion and the result being as effectual in curing the patient as psycho-analysis.

As to the causation of epilepsy Dr. Fraser strongly advocates the vaso-constriction theory plus a "toxin" and quotes freely from Hughlings Jackson in support of the former, but advances no new arguments in its favour than those dealt with by Gowers in his book "Epilepsy." Gowers rejects this theory which has many advocates and some experimental data for its support. The presence or absence of vaso-constriction is held to be a matter of secondary importance to the "toxin," which presumably causes the vaso-constriction. As to the toxin Dr. Fraser suggests that in organic cases this is supplied by the softening and breaking down of the nerve tissue in the neighbourhood of the growth and that the "toxin" in idiopathic epilepsy is due to over production or want of elimination of ordinary waste or cerebral tissue.

He does not consider the possibility of a dysfunction of the thyroid or parathyroid glands nor does he refer to work on the blood chemistry lately done.

In Chapter IV. Brown-Séquard's experimental work is referred to and its neglect justly deplored; anything writ-

ten by this great thinker and worker is worthy of the utmost respect. But as far as we are aware others have not been able to produce epilepsy experimentally as he has claimed to have done. It is extremely difficult to understand how section of a sciatic nerve can cause convulsions in a guinea pig and still more so how can it cause epilepsy in the young of those with sectioned sciatic nerves. If convulsions can be produced by this means, it tends to disprove the vaso-constriction and toxin theory, as section of the sciatic nerve could hardly influence the tone of the cerebral vessels nor could it produce a recurring toxæmia.

The influence of the glands of internal secretion is touched upon, more particularly the relationship of hypopituitarism to epilepsy; there is also a chapter devoted to many very interesting organic cases together with some post mortem notes.

The author notes that in organic epilepsy the provoking lesion is found much more often in the left than the right side of the brain. In only three of twenty patients was the lesion confined to the right lobe.

In remarks on the cerebro-spinal fluid it is suggested that there may be a hormone peculiar to the cerebral circulation which controls or helps to control the condition of the cerebral capillaries, and that it may be secreted by the choroid gland. The author gives some interesting extracts from Dixon and Halliburton's work on the methods of stimulating the secretion of cerebro-spinal fluid, the most potent being choroid gland extract. He says that he has found very little cerebro-spinal fluid *post mortem* in some patients with the worst forms of epilepsy. This is contrary to our experience. When lumbar puncture is performed in epileptics and more especially in *status epilepticus* the fluid is found to be under increased pressure. The great benefit that follows lumbar puncture in both *status epilepticus* and epileptiform convulsions of general paralysis, is undoubtedly.

With the exception of recording the cure of two patients by injections of tuberculin and the suggestion of the use of the cautery, the work contains no aids as to treatment nor does it touch upon the bio-chemistry of epilepsy, wherein lies the secret of its pathology and its successful treatment.

The book is one of great interest. But a book on a subject of which nothing is known for certain and all is speculation, must of necessity contain much that is controversial and debatable. The extracts from the great masters Brown-Séquard and Hughlings Jackson whose works are difficult of access, alone make the volume worth possessing.

GYNÆCOLOGY.

THAT the text-book of gynaecology entitled "Diseases of Women by Ten Teachers" should have run into a third edition within five years of its first publication, is evidence that there has been a considerable demand for it.¹ This is easily understood, for the work embodies the considered opinions of ten of the leading teachers in London and may be regarded as representative of English practice in gynaecology. The third edition is no larger than the previous ones and embodies no radical alterations or advancement. It is easy to read and conveys the essential facts without unnecessary "padding." There are special chapters on the psychology of chronic ill-health in women and on acute lesions of the abdomen, which are well balanced and broad in outlook. The illustrations of pelvic lymphatics have been improved, while the letterpress and block printing maintains its high standard. It is pleasing to note that there is a substantial reduction in the price, from thirty shillings to twenty-four shillings. It is to be hoped that this example will be followed by other publishers, for the present level of prices for technical medical books is very high and is a handicap to practitioners who wish to keep themselves in touch with the latest publications.

¹ "Clinical Studies in Epilepsy: Composed of Clinical Notes on Some Epilepsies as Bearing on the Pathogenesis of Idiopathic Epilepsy," by Donald Fraser, M.D., F.R.F.P. & S. (Glasgow): 1-24. Edinburgh: E. & S. Livingstone. Crown 8vo, pp. 243. Price: 7s. 6d. net.

¹ "Diseases of Women," by Ten Teachers, under the Direction of Comyns Berkeley, M.A., M.D., M.C. (Cantab.), F.R.C.P. (Lond.), edited by Comyns Berkeley, H. Russell Andrews, J. S. Fairbairn; Third Edition; 1924. London: Edward Arnold and Company. Demy 8vo, pp. 641, Illustrated. Price: 24s. net.

The Medical Journal of Australia

SATURDAY, DECEMBER 27, 1924.

The Process of Attrition.

DURING his year of office as President of the Victorian Branch of the British Medical Association Dr. J. W. Dunbar Hooper has concentrated the chief attention of his Council on a campaign to improve the practice of obstetrics. He and a few other leading obstetricians have regarded for many years the existing conditions with serious alarm. The grave harm inflicted on mothers and their infants as a result of inefficient care before, during and after child-birth has been reflected in the high mortality and morbidity among the former and the high mortality among the latter. This subject has been discussed in our columns on numerous occasions and the warnings that have been issued repeatedly, have found an echo in an ever widening sphere. The demand for some active steps to bring about an improvement in obstetric practice has existed for a long time. The introduction of the maternity bonus was the first official recognition of this demand. Unfortunately the payment of five pounds to every Australian mother has not resulted in an appreciable reduction of the maternal or infantile mortality. A few years ago the Federal Government appointed a departmental committee to inquire into the causes of death and invalidity and this committee issued a report in August, 1917, on the causes of maternal death. The report was a strong indictment of midwives and medical practitioners. Among the recommendations of the committee were that unnecessary interference in labour should be avoided, that infective conditions associated with child-birth should be notifiable, that expert control of expectant mothers should be adopted in all parts of the Commonwealth and that there should be a more advantageous expenditure of the money now distributed to women as maternity bonus. The Federal Committee of the British Medical Association

in Australia endorsed these recommendations and amplified them. The matter concerned the State Governments as well as the Federal Government. Seven years have elapsed since the Departmental Committee of the Federal Government made it quite evident that the maternity bonus had failed in its main objective and indicated how the three-quarters of a million pounds sterling each year could be invested to greater advantage for the mothers and infants of the Commonwealth. Whether political influence or vested interests have interposed need not detain us now. The fact remains that no action has been taken.

Before 1917 puerperal fever was notifiable in Queensland, South Australia and Tasmania. Since the Departmental Committee urged compulsory notification of all infective processes in connexion with parturition seven years ago, the Victorian and the Western Australian Governments have added puerperal fever to the list of notifiable diseases. Puerperal fever is not yet notifiable in New South Wales. It is true that medical practitioners have obviously not carried out their duties in notifying puerperal fever, for the number of deaths from puerperal fever recorded each year in the five States is often greatly in excess of the number of notified infections.

As a result of the insistent and repeated demands of men like Dr. Fourness Barrington, Dr. T. G. Wilson and Dr. Dunbar Hooper, the University authorities have awakened to the necessity of making a real effort to reform the training of medical students in the science and art of midwifery. It is no coincidence that has impelled Dr. D. Gifford Croll to select this urgent subject as the theme of his address on retiring from the President's chair of the Queensland Branch of the British Medical Association. Dr. Croll's advocacy adds another drop to wear away the stone of indifference and inaction. A chair of midwifery has been established in the University of Sydney and the first Professor will be appointed in a brief space of time. A strong movement is on foot in Melbourne and the result must be a remodelling of the curriculum and a vast improvement in the teaching. There are indications of better things in the near future for the University of Adelaide.

The reduction of the mortality from eclampsia, diminution of sepsis and the practical elimination of death from haemorrhage among parturient women in the large women's hospitals indicate what can be done when the management of pregnancy and labour is controlled by competent persons. It means that safety can be purchased for the whole community. Apart from the better training in obstetrics of medical students and practitioners, there is the better training of obstetric nurses and midwives and their efficient supervision, the institution in every part of each State of facilities for ante-natal care, not a perfunctory chat with the expectant mother and the rough examination of one or two samples of urine, but a conscientious and thorough control of the woman's state of health. More provision of beds in hospitals for women in labour and the establishment of a large number of private lying-in hospitals are also essentials in the campaign. There is still much preaching to be done, before the goal is reached.

Current Comment.

VITAL CAPACITY IN HEALTH AND DISEASE.

EARLIER in the year Dr. Lucy D. Cripps published a valuable report on the application of the Royal Air Force physical efficiency tests to men and women.¹ In this report the author deals with some investigations that have been carried out to determine the vital capacity, the expiratory force and the power to hold the breath in men and women. Dr. Cripps was aiming at a measurement of physical fitness and therefore correlated all the tests that are used in the Royal Air Force for the admission of recruits. She has much to say concerning breath-holding, expiratory force, variations in the systolic and diastolic blood pressure as a result of change of posture as well as the measurement of the vital capacity. It is advisable, however, to examine the last named test separately in order to determine whether or not John Hutchinson's contention that the measurement of the vital capacity is a reliable indicator in the diagnosis of pulmonary disease, can be supported. She utilized the records of nine hundred and fifty candidates who were passed into the Royal Air Force as fit and compared with these records the results of a similar examination of a selected group of women at the Physical Training College. The mean vital capacity of the women was $3,353.9 \pm 18.4$ and of the men $4,604.8 \pm 13.5$. The standard deviation

for the women was 414.5 and for the men 614.7, while the coefficient of variation was 12.36 and 13.35 respectively. She further sought to ascertain whether in a homogeneous sample of women the variations corresponded to the physical fitness of the individuals of the component groups. The students from the Physical Training School represented women supposedly in good condition. The students from Bedford College were women who played games, but did not take part in any physical training. They wore corsets. The women civil servants led sedentary lives without outdoor recreation. They, too, wore corsets. The vital capacity of these three groups was $3,353.9 \pm 18.4$, $3,209.6 \pm 34.5$ and $2,806.5 \pm 29.9$ respectively. The standard deviations were 414.5, 547.8 and 495.4 for each of the three groups. The coefficient of variation was 12.36, 17.07 and 17.65. Further study revealed that there was no correlation between the level of the vital capacity and the length of the physical training. She therefore came to the conclusion that the variability of the vital capacity is so large that it becomes impossible to employ it alone or together with other respiratory tests as a measure of physical fitness.

Dr. J. H. Arnett and Dr. K. Kornblum have sought to attack the same problem from a somewhat different point of view.¹ They wished to ascertain the diagnostic value of the test. In the first place they considered the percentage variation as measured from the normal standard. This was calculated by West's surface-area formula. Other formulae were also employed. It seems that apparently normal persons yield values varying between 70% and 140% of the standard. No normal readings were found below 70%, but they regard it as probable that lower readings might have been encountered, had the series been larger. They then considered the readings in persons suffering from pneumonia. From careful observations it transpired that in fully developed pneumonia the vital capacity reading was below 40% of the standard. Such low readings have not been encountered in normal people. The authors, however, point out that while the reduction may be of value in differential diagnosis, since it is out of all proportion to the extent of the consolidated area, the daily variations in the readings should be considered, rather than the departure of any one reading from the normal. When there is a question of the presence of purulent pleural effusion, the vital capacity curve taken in conjunction with the temperature, pulse rate and respiratory rate proved a more reliable guide to progress than even the skiagram. They conclude that it is undesirable to employ the vital capacity test in the acute stages of pneumonia for the purpose of diagnosis, but that it might be used with advantage in atypical cases to differentiate between a commencing pneumonia and bronchitis, during convalescence to control the progress of resolution and to guide the surgeon whether to operate or not in empyema, abscess or unresolved pneumonia.

¹ Medical Research Council, Special Report Series, No. 84, 1924.

¹ Annals of Clinical Medicine, October, 1924.

These investigations and several others that have been published within recent years compel us to hold the view that the ratio of the vital capacity to the body length, trunk length, chest circumference, surface area or weight or any combination of these measurements, is too variable to admit of any workable standard or normal value. On the other hand the vital capacity of each individual, after he had become accustomed to the use of the spirometer, will be found to be subject to but small variations as long as good health is maintained. There seems to be evidence to show that a reduction in the vital capacity is often the first sign of a progressive damage to the respiratory tissue.

THE CANCER CELL.

Of the many points of attack of the cancer problem, that involving the study of the cancer cell is among the oldest. It has been held by very many pathologists since the science of cytology has been evolved, that the cell of the various forms of carcinoma are phylogenetically tissue cells whose biological function has been disturbed. A glandular cell of the mamma that takes on limitless growth and at the same time neglects its function as a secretory structure, is regarded as a cancer cell. On the assumption that every cancer cell starts as a normal tissue cell, countless endeavours have been made to ascertain the agent that leads the cell to become parasitic to its host.

In 1890 von Hansemann recorded some important observations on the cancer cell itself which later gave rise to much controversy. He described the occurrence of asymmetrical mitoses. The interpretation of the difference between the mitotic figures of the growing normal cell and the cancer cell, was the subject of much speculation. Farmer, Moore and Walker challenged von Hansemann's observations concerning the number of chromosomes in typical malignant cells. Cytologists apparently have become reconciled to the general thesis that the nucleus of a cell possessed of the anomalous growth qualities of a malignant cell must of necessity be abnormal and that this abnormality extends to the chromosomes during the process of nuclear division. As far as we are aware no one has succeeded in inducing this kind of irregular or asymmetrical mitotic division by artificial means. It therefore seemed as though this avenue of investigation must lead blindly to a full stop. But with the assistance of advanced physico-chemical knowledge further attempts are being made to discover the secret of the anomalous behaviour of the cancer cell. One method of study was based on the determination of the changes in the electronic discharges within the cells of malignant tumours and aimed at the discovery of the causes of these changes from the normal. Professor F. P. Sandes is seeking to correlate the altered potassium distribution carrying with it a modification of the electronic discharge with the varying degrees of malignancy of tumour cells.

While it is not immediately apparent what the nature of the process can be that can lead to these violent changes in the cell, it is certain that the thorough study of these phenomena must be bringing us appreciably nearer to the solution of the problem.

Professor T. Brailsford Robertson has recently sought to attack the question from a somewhat similar point. In his extensive researches on the phenomena of growth, he has naturally turned his attention to the behaviour of the nucleus in normal growing young cells and in cells derived from old communities.¹ He sets up the hypothesis that in vertebrates the exhaustion of the nutrient material is not the natural limiting factor of the growth of cells, but that continued growth depends on the presence of an auto-catalizer, derived from the nucleus. When the concentration of the auto-catalyst drops below a certain level, growth is inhibited. Since cell division depends on the concentration of the auto-catalyst, it follows that a given ratio of nuclear material to the cytoplasm is essential for this process. Accumulation of the catalyst beyond a certain amount delays nuclear synthesis. It is unnecessary to reproduce in this place Professor Robertson's evidence and arguments concerning this process. He explains that failure of a cell to divide may be due to accumulation of auto-catalyst in a community of cells that has started with a nucleo-cytoplasmic ratio requisite for division or to the fact that the ratio has never reached a level essential for division in the medium in which the cell resides. The nucleo-cytoplasmic ratio needed for division of cells is therefore not a fixed level, but varies according to the tissues in which the cells are placed. In adult tissues the diminution of the nucleo-cytoplasmic ratio at the moment of cell division enables the cell community to evade the consequences of accumulation of auto-catalyst in the enclosed nutrient medium. The diminution further leads to the production of cytoplasmic structures needed for the constitution of complex organs. Ultimately, however, developmental stasis must occur. If a wound be inflicted in any tissue, repair takes place by the active division of the cells with the lowest nucleo-cytoplasmic ratio capable of dividing. If this process be repeated the type of cell which will take on the most rapid and the most energetic division, will be characterized by an increasingly low nucleo-cytoplasmic ratio. Professor Robertson sets up the hypothesis that if the removal of the repair tissue could be repeated often enough, eventually the cells undergoing division in the process of repair would be endowed with the property of continuous multiplication and consequent invasion of other tissue. On this basis he builds up the further hypothesis that cancer cells are endowed with the property of undergoing mitotic division at abnormally low nucleo-cytoplasmic ratios. He holds that such cells might arise from a peculiarity in the genetic constitution of certain cells of a particular locality or from cells with a tendency to asymmetrical mitosis.

¹ *The Journal of Cancer Research*, July, 1924.

British Medical Association News.

ANNUAL MEETING.

THE ANNUAL MEETING OF THE QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION WAS held at the B.M.A. Building, Adelaide Street, Brisbane, on December 12, 1924, Dr. D. GIFFORD CROLL, the President, in the chair.

Death of Professor J. I. Hunter.

THE PRESIDENT referred in feeling terms to the loss sustained by the profession by the death of Professor J. I. Hunter. He moved a vote of condolence to the widow and also to the Medical School of the University of Sydney. The motion was carried in silence, all the members standing.

Annual Report of the Council.

The annual report of the Council for 1924 was presented by the HONORARY SECRETARY and was taken as read. The PRESIDENT moved and Dr. D. A. CAMERON seconded the adoption of the report. This was carried unanimously. The report is as follows:

THE COUNCIL has the honour to present the following report of the work of the Branch for the year ended November 15, 1924.

Membership.

The membership of the Branch is now 371 as against 349 last year. During the year twenty-five new members have been elected, four reinstated, thirty-two transferred from other Branches, twenty-three transferred to other Branches, three resigned, ten struck off as unfinancial or addresses unknown and three deaths occurred.

The Council regrets to record the following losses by death: Dr. Thomas Davies, Emerald; Dr. T. R. McKenna, Brisbane, and Dr. Louis Birch, Clifton.

Meetings.

General Meetings.—Ten ordinary meetings and one special meeting were held, the average attendance being thirty-four. At two of the meetings sixty members were present and at another forty members. The special meeting was held to consider resolutions from the Brisbane Hospital Clinical Society regarding the establishment of a department of normal and morbid anatomy in Brisbane.

Council Meetings.—The Council held sixteen meetings. The attendance was as follows:

	Attendances.	Apologies.
DR. D. GIFFORD CROLL (President) ..	16 ..	—
DR. D. A. CAMERON (Vice-President, <i>ex officio</i>) ..	11 ..	5 ¹
DR. VAL McDOWALL (Vice-President) ..	12 ..	1
DR. R. MARSHALL ALLAN (Honorary Secretary) ..	13 ..	3
DR. G. W. MACARTNEY (Honorary Treasurer) ..	13 ..	1
DR. W. N. ROBERTSON (Federal Com- mittee Representative) ..	8 ..	5 ¹
DR. J. LOCKHART GIBSON (Federal Committee Representative) ..	11 ..	5 ¹
DR. J. V. DUHIG (Curator of Museum) ..	10 ..	2
DR. A. G. ANDERSON (Librarian) ..	9 ..	1
DR. E. CULPIN (Councillor) ..	14 ..	—
DR. J. ESPIE DODS (Councillor) ..	9 ..	6
DR. A. H. MARKS (Councillor) ..	14 ..	2
DR. E. S. MEYERS (Councillor) ..	10 ..	6
DR. S. F. McDONALD (Councillor) ..	7 ..	6
DR. A. V. MEEHAN (Councillor) ..	8 ..	4
DR. A. T. NISBET (Councillor) ..	9 ..	5
DR. THOMSON LECKIE (Councillor) ..	11 ..	3

¹ Apologies due to illness and absence at Federal Committee meetings.

² Apologies due to illness.

Papers.—The following papers were read before the Branch during the year:

February 1.—Late DR. G. E. RENNIE (read by DR. S. F. McDONALD): "Glycosuria and Diabetes."

March 7.—DR. E. SANDFORD JACKSON: "Historical Notes from Records in the Brisbane Hospital" (Part III.).

April 4.—Discussion on Anaesthetics: Opened by DR. A. P. MURPHY, C. A. THELANDER and R. E. WEAVER.

May 2.—DR. THOMSON LECKIE: "Treatment of Fractures: Methods of Splinting."

June 6.—DR. R. SCOT SKIRVING (Sydney): "Specialists and General Practitioners: Their Education and Relation to Each Other."

July 4.—(1) DR. W. CROSSE: "Notes Upon Tonsils, Adenoids and Some Middle Ear Infections in Childhood." (2) DR. GEORGE THOMPSON: "Some Eye Notes for the General Practitioner."

August 8.—SIR G. A. SYME (Melbourne): "Gall Stones."

September 5.—(1) DR. L. J. NYE (Atherton), read by the HONORARY SECRETARY: "Notes on a Visit to America." (2) SIR DAVID HARDIE: "Notes on a Visit to Europe, including Spahlinger Treatment and Helio-Therapy."

September 24.—DR. W. F. TAYLOR: "Off the Beaten Track."

October 3.—DR. J. V. DUHIG: Exhibition of Specimens from the Branch Museum. Paper entitled: "Kidney Function in Health and Disease."

November 7.—DR. A. T. NISBET: "Twenty-one Months' Experience with Deep X-Ray Therapy."

At the February meeting the paper which had been prepared by the late DR. G. E. Rennie was, with the consent of Mrs. Rennie, presented before the Branch. We have also been honoured by papers from Sir G. A. Syme and DR. Scot Skirving, both of which were highly appreciated.

The Sub-Committee responsible for the arrangement of the paper programme consisted of DR. A. G. ANDERSON, A. V. MEEHAN and E. CULPIN.

Many interesting cases and specimens were exhibited at the various meetings and the Council is much indebted to Mr. HANCOCK for his assistance in preparing slides and working the lantern.

Federal Committee.

As usual two Federal Committee meetings were held during the year, the Branch again being represented by DR. W. N. ROBERTSON and DR. J. LOCKHART GIBSON. Reports of proceedings will be found in THE MEDICAL JOURNAL OF AUSTRALIA of March 15, 1924, and August 2, 1924.

Friendly Societies and Lodges.

Personnel of Sub-Committee.

DRS. A. G. ANDERSON and E. S. MEYERS.

Model Lodge Agreement (Metropolitan Area).

This year like last one has been quiet and no complaints have been received from either the medical officers or the lodges.

Lodge Agreements—Country Areas.

A number of inquiries have been received regarding rates and income limit. The attention of the inquirers was drawn to Clause 11 of the Model Lodge Agreement, which allows the medical officers of lodges in country districts to decide this matter for themselves in agreement, subject to the approval of the Council.

Repatriation Commission: Medical Benefits for Certain Relatives of Deceased Soldiers.

The Council agreed to the scheme put forward by the Repatriation Commission and approved by the Federal Committee (*vide* THE MEDICAL JOURNAL OF AUSTRALIA, December 22, 1923, March 15, 1924, and August 2, 1924, whereby widows and orphans of

soldiers whose death is due to war service, and widowed mothers of such deceased unmarried soldiers are placed on lodge lists for medical benefits without being subject either to medical examination or income limit. Trouble was soon experienced over the working of the scheme and after further consideration the Council has forwarded the following motion to the Federal Committee for discussion at its next meeting:

As only 331 applications to be attached to lodge lists have been received up to August 31, 1924, out of about two thousand who are eligible to participate in the scheme, the Federal Committee be asked to reconsider the agreement with the Repatriation Commission and provide that:

- (a) The full number who are eligible be placed on lodge lists; or
- (b) That the number making application to be placed on lodge lists conform to the Model Lodge Agreement as regards income limit and medical examination.

The matter was subsequently referred to the Lodge Sub-Committee who recommended in their report that beneficiaries under the scheme be accepted as members of lodges under the terms of the Model Lodge Agreement and those ineligible on account of excess of income or inability to pass the medical examination be provided for by the Commonwealth Government according to schedule of minimum scale of fees.

Work of the Sub-Committees.

Hospital Sub-Committee.

Personnel of Sub-Committee.—The Sub-Committee consisted of DR. D. A. CAMERON, A. H. MARKS and THOMSON LECKIE.

As in other years the work of the Council has largely been occupied with matters in connexion with country hospitals.

Maternity Wards Attached to Public Hospitals.—Doubt has existed for some time regarding the medical attendance at these wards. The Council has been informed by the Home Secretary's Department that all registered medical practitioners in each town where such wards exist are permitted to use them. The Council recommends that the rates charged should be the same as for lodge practice in the district for confinements.

Treatment of Well-to-do Patients.—Considerable trouble has arisen in several country centres over the free treatment of persons able to pay, not only the hospital, but also the doctor. The attitude of the Home Secretary's Department is in agreement with the views of the Council and the following ruling of the Home Secretary is published for the information of members:

Public hospitals are established primarily for the treatment of persons whose circumstances are such that private medical treatment is beyond their means and only such persons are eligible for admission to hospital. All other persons are subject to private practice.

The Department has, however, not objected to private patients of the medical officer being admitted, provided that hospital fees are paid. The doctor's fee is a matter between the doctor and the patient.

Insistence on this has brought all the offending hospitals into line.

The Council is endeavouring to obtain an interview with the Home Secretary to discuss hospital matters, but owing to pressure of Parliamentary business no date has yet been fixed.

Brisbane and South Coast Hospitals Board.—The Council has had an interview with the General Medical Superintendent, Dr. J. B. McLean, regarding the rule for admission to the hospitals under the Board and also in connexion with the resident medical officers from the Mater Misericordiae Hospital seeking appointment to these hospitals, especially the Lady Bowen Lying-in Hospital and the

Hospital for Sick Children. Dr. McLean has stated that admission is based on necessity either through lack of means or emergency. He also stated that it was unfortunately impossible to provide for resident medical officers from the Mater Misericordiae Hospital being appointed to the hospitals above mentioned owing to the number of resident medical officers under the Board.

Public Health Sub-Committee.

Personnel of Sub-Committee.—DRS. J. ESPIE DODS, J. V. DUHIG and DR. S. F. McDONALD.

Royal Commission: National (Medical) Insurance.—A questionnaire was circulated to members in order to obtain evidence for this Commission. The President and Honorary Secretary gave evidence before the Commission and a résumé of the President's remarks was published in THE MEDICAL JOURNAL OF AUSTRALIA of April 12, 1924. Following on a request for a constructive scheme by the Chairman of the Commission, the Sub-Committee drew up such a scheme which was forwarded to the Federal Committee of the British Medical Association and also to the Royal Commission and published in THE MEDICAL JOURNAL OF AUSTRALIA of May 31, 1924.

Pure Milk Supply (Metropolitan Area).—The Sub-Committee in association with other interested bodies were present at a deputation to the Home Secretary on this important matter.

Publicity Sub-Committee.

Personnel of Sub-Committee.—DRS. J. ESPIE DODS, J. V. MACARTNEY and S. F. McDONALD. No publications were made by this Sub-Committee during the year.

General.

Incorporation of Branch.

During the year the model Memorandum and Articles of Association for incorporation of the Branch as a limited company was received from the Federal Company. On the advice of our solicitors it was resolved to apply to the Treasury for permission to register with limited liability without the addition of the word "Limited." This was granted under conditions that certain provisos were included in the Memorandum. As this means altering the model set of rules common to all the Australian Branches, permission will have to be granted by the London Office, which is at present being applied for.

Proposed Department of Normal and Morbid Anatomy.

Early in the year a resolution regarding the desirability of establishing a Department of Normal and Morbid Anatomy in association with the Brisbane Hospital, was received from the General Hospital Clinical Society and considered at a special general meeting of the Branch, when it was unanimously carried. A Sub-Committee was appointed consisting of DR. E. S. JACKSON (subsequently appointed chairman), DR. J. V. DUHIG, E. S. MEYERS, W. N. ROBERTSON and S. F. McDONALD and later two representatives of the dental profession were added, MESSRS. PARKER and PENNYCUIK. It was suggested that the McGregor Memorial Fund might with the consent of the subscribers finance the scheme in part, the Department to be under the control of the University authorities. A deputation of representatives of the University and professions laid the scheme, so far as it could be formulated, before the Home Secretary, who referred the matter to the Medical Superintendent of the Brisbane Hospital and the Commissioner of Health, whose reports have been received and were favourable. A further conference with the Home Secretary is being arranged which will consist of representatives from the Commonwealth and State Governments, the Queensland University Senate and the dental and medical professions.

Eye, Ear, Nose and Throat Section.

During the year permission was granted to form the above Section in connexion with the Branch. DR. J. J. LOCKHART GIBSON was appointed President and DR. E. CULPIN, Honorary Secretary.

War Memorial Tablet.

The name of HAROLD SOUTH was added to the six already commemorated thereon.

Branch Dinner.

A successful dinner was held in August at the Belle Vue Hotel, when fifty-one members were present. The guests of honour were: Dr. Mervyn Archdale, Assistant Editor, THE MEDICAL JOURNAL OF AUSTRALIA, and Dr. W. C. Sweet, Director of the Hookworm Campaign. Sir George Syme was unavoidably detained from being present.

Museum.

The Curator reports that a few new specimens have been added to the collection during the year. An exhibition of some of the specimens was given at the October meeting of the Branch.

Library.

We are indebted to Mr. James Evans, Darra, for an old book entitled "History of the Great Plague" and to Dr. Eustace Russell for the "Annals of Surgery" and Dr. C. A. Thelander for *The Practitioner*.

In response to a request which appeared in THE MEDICAL JOURNAL OF AUSTRALIA, a number of duplicate copies of old issues of *The Lancet*, *The British Medical Journal* et cetera were forwarded to the Walter and Eliza Hall Institute of Research, Melbourne.

R. MARSHALL ALLAN,
Honorary Secretary.

Financial Statement.

The balance sheet and statement of receipts and payments were presented by the HONORARY TREASURER and taken as read. The adoption was moved by the PRESIDENT, seconded by DR. D. A. CAMERON and carried unanimously.

Election of Office Bearers.

The PRESIDENT announced the result of the ballot for the election of office bearers and members of the Council as follows:

President: Dr. Val McDowell.

President Elect: Dr. E. Sandford Jackson.

Vice-President: Dr. D. Gifford Croll, C.B.E.

Delegates on the Federal Committee: Dr. W. N. Robertson, C.B.E., and Dr. J. Lockhart Gibson.

Honorary Secretary: Dr. R. Marshall Allan, M.C.

Honorary Treasurer: Dr. G. W. Macartney, D.S.O.

Honorary Librarian: Dr. Neville G. Sutton.

Honorary Curator of Museum: Dr. J. V. Duhig.

Members of Council: Dr. E. Culpin, Dr. J. B. Dixon, C.B.E., Dr. J. Espie Dods, D.S.O., M.C., Dr. H. V. Foxton, Dr. A. H. Marks, C.B.E., D.S.O., Dr. S. F. McDonald, Dr. J. V. McLean, D.S.O., Dr. E. S. Meyers.

President's Address.

DR. D. GIFFORD CROLL, the retiring President, delivered his address (see page 63).

Induction of President.

DR. GIFFORD CROLL then introduced DR. VAL McDOWELL, the new President, and vacated the chair in his favour.

DR. McDOWELL thanked the members for the honour they had conferred on him in electing him President. He also thanked Dr. Gifford Croll for his valuable and interesting address.

In returning thanks, DR. CROLL asked the Branch to accept a copy of Spiegelberg's "Midwifery."

BRITISH MEDICAL ASSOCIATION (QUEENSLAND BRANCH).

Balance Sheet as at November 15, 1924.

LIABILITIES.	£	s.	d.	ASSETS.	£	s.	d.
Accumulation Fund—				B.M.A. Rooms, Adelaide Street—			
Balance, November 15, 1923 ..	1,005	14	4	Library	150	0	0
Add Surplus of Income over Expenditure for year ended November 15, 1924	100	13	7	Book Cases	25	0	0
British Medical Association, London—				Furniture and Fittings, Lantern, etc.	100	0	0
Members' Subscriptions held by Branch to be remitted to London	38	5	0	Museum Specimens	20	0	0
Australasian Medical Publishing Company, Limited—					295	0	0
Balance due at November 15, 1924, being payment for Jour- nals supplied to members to be remitted to Sydney	17	10	0	The Queensland Medical Land Investment Co., Ltd.—			
Harold Plant Memorial Fund—				1,235 Shares paid to 10s. per share	617	10	0
Capital	200	0	0	Cash at Banks and in Hand—			
Income accrued	59	15	11	Credit Balance, National Bank of Australasia, Ltd., Brisbane ..	30	19	4
	259	15	11	Credit Balance, Commonwealth Savings Bank, Brisbane ..	210	3	0
	£1,421	18	10	Cash in Hand	8	10	7
					249	12	11
				Harold Plant Memorial Fund—			
				Commonwealth 4½% War Loan (1925): £200 at cost	198	0	0
				Credit Balance, Commonwealth Savings Bank, Brisbane ..	61	15	11
					259	15	11
					£1,421	18	10

Audited and found correct,
ROY G. GROOM, F.C.P.A., Auditor.

Brisbane,
November 20, 1924.

(Signed) G. W. MACARTNEY,
Honorary Treasurer.

BRITISH MEDICAL ASSOCIATION (QUEENSLAND BRANCH).

Statement of Receipts and Payments for Twelve Months ended November 15, 1924.

University Intelligence.

UNIVERSITY OF MELBOURNE.

On December 15, 1924, the Council of the University of Melbourne, having received a certificate from Sir Henry Maudsley to the effect that Professor Sir Harry Allen would be permanently incapacitated for professional duties, proceeded to appoint a new Professor of Pathology. The successful applicant for the chair is Dr. Peter MacCallum, M.C., of Edinburgh. Dr. MacCallum graduated as M.Sc., M.A., at the University of New Zealand and obtained a New Zealand Rhodes Scholarship. He graduated in medicine at Edinburgh in 1914 with First Class Honours. He holds the Scottish Diploma of Public Health. We congratulate Professor MacCallum on his important appointment.

Proceedings of the Australian Medical Boards.

NEW SOUTH WALES.

THE undermentioned have been registered under the provisions of the *Medical Act, 1912 and 1915*, as duly qualified medical practitioners:

BARCLAY, FRANCIS EDISON, M.B., 1924 (Univ. Sydney), Wagga Wagga.
 BEVERIDGE, RUBY SCOURL, L.R.C.P., 1923 (Edin.), L.R.C.S., 1923 (Edin.), L.R.F.P.S., 1923 (Glasgow), Roseville.
 EGAN, EDWARD CHARLES, M.B., Ch.M., 1924 (Univ. Sydney), 25, Denison Street, Waverley.
 FARROW, CLAUDE WILLIAM HENRY, M.B., Bac. Surg., 1924 (Univ. Melbourne), Balldale, near Corowa.
 FRY, WALTER BRUCE, M.B., 1924 (Univ. Sydney), Ingalaria, Turramurra.
 GALBRAITH, THOMAS, M.B., 1924 (Univ. Sydney), Canterbury Street, Hurstville Park.
 JACKSON, ROBERT JAMES, M.B., Ch.M., 1924 (Univ. Sydney), Toowoomba, Queensland.

VICTORIA.

THE undermentioned has been registered, under the provisions of the *Medical Act, 1915*, as a duly qualified medical practitioner:

GRANT, WEMYSS GORDON, M.B., B.S., 1924 (Univ. Melbourne), 30, Powlett Street, East Melbourne.

Additional Diploma Registered.

SCHWARTZ, ZELMAN, Dip. Ophth. R.C.P. (London), R.C.S., 1923 (England), F.R.C.S., 1924 (Edinburgh).

Books Received.

MODERN DIAGNOSIS AND TREATMENT OF SYPHILIS, CHANCREOID AND GONORRHOEA, by L. W. Harrison, D.S.O., M.B., Ch.B., M.R.C.P.E., Brevet-Colonel R.A.M.C. and K.H.P. (Ret.); Modern Medical Monographs, Edited by Hugh Maclean, M.D., D.Sc.; 1924. London: Constable and Company, Limited; Sydney: Angus & Robertson, Limited. Demy 8vo, pp. 167, with illustrations.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xvi.

UNIVERSITY OF ADELAIDE: Marks Lectureship in Applied Physiology and Sheridan Fellowship.
 SAINT VINCENT'S HOSPITAL, SYDNEY: Assistant Honorary Surgeon.

Medical Appointments: Important Notice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429, Strand, London, W.C..

BRANCH.	APPOINTMENTS.
NEW SOUTH WALES: Honorary Secretary, 30 - 34, Elizabeth Street, Sydney.	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phoenix Mutual Provident Society.
VICTORIAN: Honorary Secretary, Medical Society Hall, East Melbourne.	All Institutes or Medical Dispensaries. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND: Honorary Secretary, B.M.A. Building, Adelaide Street, Brisbane.	Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIAN: Honorary Secretary, 12, North Terrace, Adelaide.	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIAN: Honorary Secretary, Saint George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND (WELLINGTON DIVISION): Honorary Secretary, Wellington.	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

JAN. 6.—New South Wales Branch, B.M.A.: Council (Quarterly).
JAN. 8.—Victorian Branch, B.M.A.: Council.
JAN. 10.—Queensland Branch, B.M.A.: Council.
JAN. 10.—South Australian Branch, B.M.A.: Council.
JAN. 13.—New South Wales Branch, B.M.A.: Ethics Committee.
JAN. 14.—Tasmanian Branch, B.M.A.: Branch.
JAN. 17.—Northern Suburbs Medical Association, New South Wales.
JAN. 20.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
JAN. 22.—Victorian Branch, B.M.A.: Council.
JAN. 24.—Queensland Branch, B.M.A.: Council.
JAN. 27.—New South Wales Branch, B.M.A.: Medical Politics Committee; Organization and Science Committee.
JAN. 28.—Victorian Branch, B.M.A.: Council.
FEB. 3.—Tasmanian Branch, B.M.A.: Council.
FEB. 4 AND 5.—Federal Committee of the British Medical Association in Australia: Meeting at Melbourne.
FEB. 6.—Queensland Branch, B.M.A.: Branch.
FEB. 10.—New South Wales Branch, B.M.A.: Ethics Committee.
FEB. 12.—Victorian Branch, B.M.A.: Council.
FEB. 12.—South Australian Branch, B.M.A.: Council.
FEB. 13.—Queensland Branch, B.M.A.: Council.
FEB. 17.—New South Wales Branch, B.M.A.: Executive and Finance Committee.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to "The Editor," THE MEDICAL JOURNAL OF AUSTRALIA, B.M.A. Building, 30-34, Elizabeth Street, Sydney. (Telephone: B. 4635.)

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